Milwaukee County, #714852
Wellness Program
Reimbursement Request

KEYABLE CLAIM

Provider EIN: 06-9000001
Diagnosis Code: **799.99**

* Health club membership: **DATE:** From: _____ To: _____
Place of Service: **CL** Procedure Code: **S9970** Total Charge: $_____

* Weight loss membership: **DATE:** From: _____ To: _____
Place of Service: **CL** Procedure Code: **S9449** Total Charge: $_____

Identification Number: _____

Employee Name: _____

Address: _____

_____

Member Name: _____

Relationship (check one): Subscriber _____
Dependent _____

All benefit payments will be sent to the subscriber's address on file.

Certification and Authorization (this form must be signed and dated below)
I authorize the release of information to UnitedHealthcare about my health club and/or weight loss program membership. I certify the information provided is complete and correct and that I have not previously submitted for reimbursement of these expenses.

Subscriber/Member
Signature_____Date_____

Submit this completed form with receipts to: Springfield Claim Office
PO Box 30555
Salt Lake City, UT 84130-0555